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by deleting Sections 2 through 11 in their entirety and substituting instead the following:

SECTION 2. As used in this act "managed health insurance issuer" means an entity (1) that offers health insurance coverage or benefits under a contract, other than an individual health insurance contract, that restricts reimbursement for covered services to a defined network of providers and (2) that is regulated under this title or is an entity that accepts the financial risks associated with the provision of health care services by persons who do not own or control, or who are not employed by, such entity.

POINT OF SERVICE

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 32, is amended by adding the following as new sections to be appropriately designated:

Section __.

(a)(1) Every managed health insurance issuer shall offer, or contract with another carrier to offer, an additional benefit at the option of the employee, or other enrollee, as follows:

(A) a point of service option which provides benefits for covered services through health professionals and providers who are not members of such a network; or

(B) a preferred provider organization plan.

(2) The managed health insurance issuer shall fully disclose to the enrollee, in clear, understandable language, the terms and conditions of each

option, the co-payments or other cost-sharing features of each option and the costs associated with each such option provided by the issuer. The commissioner shall promulgate rules regarding presentation of these terms and conditions, including a suggested standard format, to facilitate the comparison by the enrollee of the terms and conditions of each option. The obligation of a managed health insurance issuer to make the offer described in this section may be satisfied by the managed health insurance issuer providing to the employer or other plan sponsor presentation materials for dissemination to employees or enrollees.

(b) The amount of any additional premium required for the options described in subsection (a) may be paid by the purchaser of the health plan or may be paid by the enrollee of such group. Such additional premium, taking into account any co-payments or other cost-sharing features, shall not exceed an amount that is fair and reasonable in relation to the benefits provided, as determined by the commissioner of commerce and insurance.

(c)(1) Under the option described in subsection (a), the rate of reimbursement for health providers out of the network shall be the same as the rate of reimbursement for non-capitated providers in the network, provided that co-payment, co-insurance and other cost-sharing features may be different for out of network providers.

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(2) A managed health insurance issuer shall not be required to reimburse an out of network provider for non-emergency services unless such provider:

(A) has disclosed to the patient a reasonable range of the total charges for the services being provided; and

(B) has advised the patient that the provider may bill the patient for the balance of any charges which are not otherwise reimbursed by the managed health insurance issuer. If, after request by the patient, the provider fails to disclose a reasonable range of the total of charges for any non-emergency services provided, the patient shall not be liable for such charges.

(d) The option described in subsection (a) shall be a part of every contract issued by a managed health insurance issuer, provided, however, an employer who employs less than twenty-five (25) full time employees may reject the point of service option in writing.

(e) The requirements of this section shall be satisfied if the employer or other person sponsoring the health insurance or health benefits plan includes for all enrollees a preferred provider organization plan or a point of service benefit as specified in this act.

(f) Nothing contained in this section shall be construed or interpreted as applying to the TennCare programs administered pursuant to the waivers

approved by the United States Department of Health and Human Services or to entities which qualify to participate in the Medicare + Choice program.

Section __. Notwithstanding any other provision of the law to the contrary, a health maintenance organization may underwrite directly the point of service benefit required by this act.

NETWORK ADEQUACY

SECTION 4. Tennessee Code Annotated, Section 56-32-203(e), is amended by adding the following language after the first sentence:

The applicant shall meet the network adequacy requirements established pursuant to Section 5 of this act.

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 7 is amended by adding the following language as a new, appropriately designated section:

Section __.

(a) Each managed health insurance issuer that offers a plan that limits its enrollees' choice of providers shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to network adequacy standards established by the

managed health insurance issuer, specifically:

(1) Primary care provider-covered person ratios;

(2) Geographic accessibility;

The network adequacy standards description shall be filed with the commissioner and updated annually.

(b) In addition to establishing the standards required pursuant to subsection (a), the managed health insurance issuer's network shall demonstrate the following:

(1) An adequate number of acute care hospital services, within a reasonable distance or travel time;

(2) An adequate number of primary care providers within not more than thirty (30) miles distance or thirty (30) minutes travel time at a reasonable speed;

(3) An adequate number of specialists and sub-specialists, within a reasonable distance or travel time;

(4) A comprehensive listing, made available to covered persons and health care providers, of the plan's network participating providers and facilities, and the listing shall be supplemented to show additions and deletions, if any exist, at least annually;

(5) The procedures for making referrals within and outside its network that, at a minimum, shall include the following:

(A) A process for expediting the referral process when indicated by a medical condition; and

(B) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse, subject to the eligibility and coverage provisions of the contract;

(6) The process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in plans;

(7) The quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(8) The system for ensuring the coordination of care for covered persons receiving approved care from specialty providers;

(9) Any other information required by the commissioner to determine compliance with the provisions of this part.

(c) In any case where the managed health insurance issuer has no participating providers to provide a covered benefit, the managed health insurance issuer shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a network provider.

(d) In determining whether a managed health insurance issuer has complied with this section, consideration shall be given to the relative availability of health care providers, specialists and subspecialists in the service area under consideration. Relative availability includes the acceptance by the health care providers, specialists or subspecialists of the terms, conditions and fees offered under the contract or plan. A network shall not be deemed inadequate solely because the network does not include a provider, specialist or subspecialist who is the sole provider in the community, if such provider, specialist or subspecialist refuses to contract with the managed health insurance issuer on terms and conditions substantially similar to providers, specialists or subspecialists in contiguous communities.

(e) Health care providers who participate in a managed care insurance issuer's plan shall provide timely appointments to patients and shall see the patients on a timely basis after arrival for an appointment. A managed health insurance issuer may include in its contracts with health care providers provisions which establish the meaning of "timeliness".

(f) Providers who do not participate in a managed health insurance issuer's plan but seek reimbursement through the point of service option mandated in Section 3 of this Act shall have the obligation to provide appointments on a timely basis and, upon arrival for appointments, the provider shall see the patient on a timely basis, provided, such timeliness shall be

consistent with usual and customary standards for the community wherein the provider is located. Frequent and repetitive failure to comply with this subsection may be cause for the managed health insurance issuer to withhold reimbursement from the non-participating provider.

SCOPE OF SERVICES

SECTION 6. Tennessee Code Annotated, Title 56, is amended by adding the following as a new chapter to be appropriately designated:

Section __. The managed health insurance issuer shall not discriminate with respect to participation, referral, reimbursement of covered services or indemnification as to any provider who is acting within the scope of the provider's license or certification under state law, solely on the basis of such license or certification. In selecting among providers of health services for membership in a provider network, the managed health insurance issuer or other network shall not discriminate against a class of providers who provide services that are covered by the plan by prohibiting such class of providers from membership in the provider network. This section shall not be construed as prohibiting managed health insurance issuers from including providers or classes of providers only to the extent necessary to meet the needs of the managed health insurance issuer's plan and its enrollees or from limiting referrals or establishing any other measure designed to maintain quality and control costs consistent with the responsibilities of the plan. This chapter shall not be construed as creating coverage for any service that is not otherwise covered under the terms of the managed health insurance issuer's plan.

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Section __. As used in this chapter, "class of providers" of health care includes optometrists, ophthalmologists, nurse practitioners, and chiropractors.

DIRECT ACCESS

SECTION 7. Tennessee Code Annotated, Title 56, Chapter 7, Part 23 is amended by adding the following language as a new, appropriately designated section:

Section __.

(a)(1) Enrollees under a plan or contract of a managed health insurance issuer that provides reimbursement for services within the scope of practice of an obstetrician/gynecologist shall be permitted at least one (1) annual preventative care visit to such obstetrician/gynecologist without obtaining a referral from a primary care provider.

(2) Enrollees under a plan or contract of a managed health insurance issuer that provides reimbursement for eye care and/or vision care services shall be permitted at least one (1) annual visit to obtain such covered services and necessary follow-up care related to the treatment, plus emergency visits as defined by the contract, from any optometrist or ophthalmologist included in the managed health insurance issuer's network without obtaining a referral from a primary care provider and the enrollee shall be permitted to obtain from the provider selected by the enrollee the full range of covered eye care and/or vision care services within the scope of that provider's license.

(3) A provider who provides obstetrical/gynecological services or eye care and/or vision care to an enrollee shall have an affirmative obligation to communicate to an enrollee's primary care physician, if any, all significant information which is relevant to that enrollee's overall state of health.

(4) Nothing in this subsection shall be construed as exempting the above treatment from the normal utilization review or quality control processes of the plan or contract.

(b)(1) Each managed health insurance issuer shall develop and maintain written policies and procedures to designate specialists or subspecialists, as approved by the medical director of such plan, as primary care providers of enrollees or subscribers with life threatening, chronic, disabling or degenerative conditions or diseases which require ongoing specialty care. The policies and procedures shall provide an appeals process for any denials of such specialists or subspecialists as primary care providers. The managed health insurance issuer may require that such specialists or subspecialists meets all other terms, conditions and reimbursement rates generally imposed by the managed health insurance issuer on its primary care providers.

(2) Each managed health insurance issuer shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers or enrollees with chronic and disabling conditions which require

ongoing specialty care authorized by the primary care physician. The standing referral shall be for a period not to exceed twelve (12) months.

(c) Nothing in this section shall be construed as creating coverage for any service that is not otherwise covered under the terms of the managed health insurance issuer's plan.

CONTINUITY OF CARE

SECTION 8. Tennessee Code Annotated, Title 56, Chapter 7, Part 23 is amended by adding the following language as a new, appropriately designated section:

Section __.

(a) If a provider who is a member of a managed health insurance issuer's network terminates its agreement with the issuer, or the issuer terminates the provider without cause, then the provider and issuer shall allow a subscriber or enrollee:

(1) who is under active treatment for a particular injury or sickness, to continue to receive covered benefits from the treating provider for such injury or sickness for a period of one hundred twenty (120) days from the date of notice of termination,

(2) who is in the second trimester of pregnancy to continue care with a treating provider until completion of postpartum care,

(3) who is being treated at an inpatient facility to remain at the facility until the patient is discharged.

(b) The provisions of subsection (a) shall apply only if the treating provider or inpatient facility agrees to continue to be bound by the terms, conditions and reimbursement rates of the provider's agreement with the issuer.

PHARMACY AND PHARMACY ACCESS

SECTION 9. Tennessee Code Annotated, Title 56, Chapter 7, Part 23 is amended by adding the following language as new, appropriately designated sections:

Section __. No health insurance issuer may:

(1) Deny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy, contract or plan; provided, however, nothing herein shall prohibit a managed health insurance issuer from establishing rates or fees that may be higher in non-urban areas or in specific instances where a managed health insurance issuer determines it necessary to contract with a particular provider in order to meet network adequacy standards or patient care needs.

(2) Prevent any person who is a party to or beneficiary of any policy, contract or plan from selecting a licensed pharmacy of such person's choice to furnish the pharmaceutical services offered under any contract, policy or plan, provided the pharmacy is a participating provider under the same terms and conditions of the contract, policy or plan as those offered any other provider of pharmacy services;

(3) Permit or mandate any difference in coverage or impose any different conditions, including co-payment fees, so long as the provider selected is a participant in the contract, policy or plan involved.

Section __. Notwithstanding any provision of this chapter to the contrary, a health insurance issuer may restrict an abusive or heavy utilizer of pharmacy services to a single pharmacy provider for non-emergency services so long as the individual to be restricted has been afforded the opportunity to participate in the process of selection of the pharmacy to be used or has been given the right to change the pharmacy to be used to another participating provider of pharmacy services prior to such restriction becoming effective. After a restriction is effective, the individual so restricted shall have the right to change a pharmacy assignment based on geographic changes in residence or if the member's needs cannot be met by the currently assigned pharmacy provider.

Section __. If a managed health insurance issuer revises its drug formulary to remove a drug from a previously approved formulary, the health insurance issuer shall allow a subscriber or enrollee an opportunity to file a grievance relative to the decision to remove such drug. The grievance must be filed within thirty (30) days after notification to the provider that the drug is being removed. If the grievance is filed with a managed health insurance issuer within ten (10) days after the notification, the subscriber or enrollee may continue to receive the drug that is being removed from the formulary until the managed

health insurance issuer completes the grievance process. The provisions of this paragraph shall not apply to any drug removed from a previously approved formulary when the reason for such removal is due to patient care concerns or other potentially detrimental effects of the drug.

NOTICE FOR PROVIDERS

SECTION 10. Tennessee Code Annotated, Title 56 is amended by adding the following as a new chapter to be appropriately designated:

Section __. (a) A managed health insurance issuer shall not terminate or nonrenew a contract with a health care provider, or take other retaliatory action against a health care provider, because the provider:

(1) communicated with an enrollee with respect to the enrollee's health status, health care or treatment options, if the health care provider is acting in good faith and within the provider's scope of practice as defined by law;

(2) disclosed accurate information about whether a health care service or treatment is covered by an enrollee's health coverage plan; or

(3) expressed personal disagreement with the decision made by the managed health insurance issuer regarding treatment or coverage provided to a patient of the provider, or assisted the enrollee in pursuing the grievance process relative to such decision of the managed health

insurance issuer, provided the health care provider makes it clear that the provider is acting in a personal capacity, and not as a representative of, or on behalf of, the managed health insurance issuer.

(b) Nothing in this section shall prohibit:

(1) a managed health insurance issuer from taking action against a provider if the health plan has evidence that the provider's actions are illegal, constitute medical malpractice or are contrary to accepted medical practices, or

(2) a contract provision or directive that requires any contracting party to keep confidential or to not use or disclose specific amounts paid to a provider, provider fee schedules, provider salaries and other proprietary information of a specific contract issued by a managed health insurance issuer, or

(3) a managed health insurance issuer from making a determination not to pay for a particular medical treatment or service or to enforce reasonable peer review or utilization review protocols.

Nothing in this subsection shall be construed as permitting retaliatory action by a managed health insurance issuer against a provider because the provider disclosed to the patient accurate information regarding the basis of such provider reimbursement.

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Section __. This chapter shall not be construed to create a cause of action or remedy that would not exist in the absence of this section, except for the purposes of enforcing the prohibitions set forth herein.

Section __. A managed health insurance issuer shall develop and implement procedures to ensure that health care providers are regularly informed of information maintained by the issuer to evaluate the performance or practice of the health care provider. The issuer shall consult with health care professionals in developing methodologies to collect and analyze provider profiling data. Managed health insurance issuers shall provide any such information and profiling data and analysis to such health care providers.

SECTION 11. The effects of the provisions of this act shall be reviewed and studied by the Department of Commerce and Insurance, the Department of Health and the Comptroller of the Treasury, and their joint report relative to the social, fiscal and economic impact of this act shall be submitted to the General Assembly on or before February 1, 2001. The provisions of Sections 7 and 9 shall expire and be of no force and effect as of July 1, 2001.

SECTION 12. The provisions of this act shall not apply to dental service plans licensed under Tennessee Code Annotated, Title 56, Chapter 30.

SECTION 13. This act shall take effect January 1, 1999, the public welfare requiring it.